DISTRICT OF COLUMBIA
DOH OFFICE OF ADJUDICATION AND HEARINGS

DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH Petitioner, v. HFM ENTERPRISES, INC. and HILBERT H. HUMPHREY Respondents	Case No.: I-02-90007

FINAL ORDER

I. Introduction

This case arises under the Civil Infractions Act of 1985 (D.C. Official Code §§ 2-1801.01 *et seq.*) and Title 22 Chapter 38 of the District of Columbia Municipal Regulations ("DCMR"). By Notice of Infraction (No. 90007) served June 11, 2002, the Government charged Respondents HFM Enterprises, Inc. and Hilbert H. Humphrey with a violation of 22 DCMR 3835.5 for allegedly failing to comply with staffing requirements. The Notice of Infraction charged that Respondents violated 22 DCMR 3835.5 on June 7, 2002 at 2016 Fendall Street, S.E., and sought a fine of $500.

Respondents answered the Notice of Infraction with a timely plea of Deny pursuant to D.C. Official Code § 2-1802.02(a)(3), and an evidentiary hearing was held on September 13, 2002. Sheila Kelly, the charging inspector in the case, appeared on behalf of the Department of Mental Health ("DMH"), accompanied by her supervisor, Lynne Riggins, Director for DMH's Division of Licensure. Hilbert Humphrey, who identified himself as the owner and director of HFM Enterprises, appeared on behalf of Respondents. Based upon the testimony of the

witnesses and my evaluation of their credibility, the admitted documentary evidence and the entire record in this matter, I now make the following findings of fact and conclusions of law:

II. Findings of Fact

At all times relevant to this matter, Respondent Hilbert Humphrey served as the owner and director of Respondent HFM Enterprises ("HFM"). HFM operates 24-hour community residence facilities at 2016 Fendall Street, S.E. ("2016 Facility") and at 2020 Fendall Street, S.E. ("2020 Facility"). Although physically connected, these facilities are separately licensed. The entrance to both facilities, however, is located at 2016 Fendall Street, S.E. At all times relevant to this matter, the 2016 Facility housed eight residents.[1]

On June 7, 2002 at approximately 7:15 PM, Ms. Kelly visited the 2016 Facility where she was met at the door by Isabella Frasier, a staff person employed by HFM as the Residence Director for the 2020 Facility. Petitioner's Exhibit ("PX") 100. Ms. Frasier informed Ms. Kelly that she was the only staff person on duty for the 2016 Facility and 2020 Facility. At the time of Ms. Kelly's visit, Ms. Frasier advised her that she had called the police earlier that day because one of the residents had been exhibiting violent and aggressive behavior, and that, because she

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[1] There is potentially conflicting evidence regarding the number of residents at the 2016 Facility on June 7, 2002. Mr. Humphrey testified that on June 7, 2002, the 2016 Facility had eight residents. As of June 11, 2002, however, evidence proffered by the Government indicates that the 2016 Facility "currently" had nine residents. PX 100. Of course, the number of residents that a particular facility is licensed to care for may be equal to or greater than the number of actual residents. In this instance, however, there is uncontroverted testimony from Respondents that, on June 7, 2002, there were eight residents at the 2016 Facility, and in the absence of evidence in the record that an additional resident entered that facility between June 7, 2002 and June 11, 2002, I credit that testimony. In addition, because the 2020 Facility was not listed by the Government as the location of the infraction, I make no findings as to the number of residents it housed on June 7, 2002. *See* pages 5-6 *infra*.

was the only staff person on duty for both facilities, she had been afraid for her safety.[2] *See* PX 100 and 101. Ms. Kelly did not inspect the 2016 Facility that evening. Upon leaving the 2016 Facility at approximately 7:30 PM, Ms. Kelly left Statements of Deficiency for the 2016 Facility and 2020 Facility with Ms. Frasier, with instructions that they be forwarded to Mr. Humphrey. PX 103.

There is conflicting evidence in the record as to whether Ms. Frasier was the only staff person on duty at the time of Ms. Kelly's visit on June 7, 2002 at 7:15 PM. *Compare* PX 100 *with* PX 104. As noted above, according to Ms. Kelly, Ms. Frasier advised her that no other staff person was present at either the 2016 Facility or the 2020 Facility that evening. Mr. Humphrey testified, however, that Ms. Frasier advised him that, unbeknownst to her, another staff person, Kwanchia Wannaprake, Residence Director for the 2016 Facility, was on the premises.[3] PX 100; PX 104. Mr. Humphrey testified that Mr. Wannaprake resides at the premises, and that he sometimes leaves the premises for errands and may not always advise other staff when he is leaving or when he returns. Mr. Humphrey further testified that Mr. Wannaprake had left the premises on June 7, 2002 when two other staff persons were present, identified for the record as being Ms. Frasier and Victoria Solotri; that Mr. Wannaprake returned to the premises by 6:00 PM prior to Ms. Solotri's departure; and that, during the time of Ms. Kelly's visit, he was in the bathroom. *See* PX 104.

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[2] The police removed the resident from the 2016 facility on June 7, 2002. PX 102. There is no evidence in the record indicating the precise time of removal, however. *Cf.* PX 101 (indicating time and date of incident to be 4:00 PM on June 7, 2002, but not indicating when police were called or when they arrived).

[3] According to Mr. Humphrey, Ms. Frasier believed that she was the only staff person on the premises because she did not see Mr. Wannaprake's car parked outside. Mr. Humphrey further testified that Mr. Wannaprake had left his car at a repair garage earlier that day.

Neither Mr. Wannaprake nor Ms. Frasier was called to testify by the parties in this matter, and as such, cannot directly confirm either version of events. Moreover, while Mr. Humphrey was not at the 2016 Facility at the time of Ms. Kelly's visit and, as such, relies on statements from Ms. Frasier and Mr. Wannaprake, Ms. Kelly did not make an independent determination that evening that Ms. Frasier was the only staff person on the premises. The issue I must resolve for purposes of this disposition, therefore, is whether what Ms. Frasier believed to be true, *i.e.*, that she was the only staff person present at the 2016 Facility and the 2020 Facility on June 7, 2002 at the time of Ms. Kelly's visit, has been established by a preponderance of the evidence.

According to the Government, Ms. Frasier stated to Ms. Kelly on June 7, 2002 that "**because she was the only staff person on duty** for both facilities, **she was afraid** of being physically harmed by the [resident]." PX 100 (Emphasis supplied). Such a depiction of events conflicts, however, with the depiction provided by Ms. Fraiser in her June 7, 2002 DMH Unusual Incident Report which indicates that, at least as of 4:00 PM that day, other staff were on the premises, and that the resident had frightened them as well: "**I was afraid** of [the resident] also the residents **and other staff**." PX 101. (Emphasis supplied). Given this facial inconsistency in the Government's own evidence, I give limited weight to Ms. Frasier's assertion, standing alone, that she was the only staff person on duty at the time of Ms. Kelly's visit on June 7, 2002.

The incredulity of the testimony offered by Respondents, however, tends to bolster Ms. Frasier's assertion. Mr. Humphrey testified that, unbeknownst to Ms. Frasier, Mr. Wannaprake was on the premises from at least 6:00 PM until after Ms. Kelly left the premises at 7:30 PM. Respondents speculate that Ms. Frasier was unaware of Mr. Wannaprake's presence during this

approximately 90-minute interval because his car was not parked outside and/or he was using the bathroom.

I do not find such speculation to be credible. It is difficult to conceive that, given the limited number of residents and the physical limitations of the premises in general, Ms. Fraiser would not have known Mr. Wannaprake had been present for well over an hour particularly if, as Respondents suggest, he was scheduled to be on duty that evening. Moreover, other than the testimony that Mr. Wannaprake was in the bathroom during Ms. Kelly's visit, no other specific evidence was provided as to his whereabouts during the remainder of the 90-minute period. By a preponderance of the evidence, therefore, I find that Ms. Frasier was the only staff person at the 2016 Facility and 2020 Facility on June 7, 2002 between 7:15 PM and 7:30 PM.

Upon receipt of the Notice of Infraction, Mr. Humphrey gave verbal warnings to his staff at the 2016 Facility and 2020 Facility to improve their communication skills such that staff whereabouts are known at all times or risk termination.

III. Conclusions of Law

The Government has charged Respondents with violating 22 DCMR 3835.5 at the 2016 Facility on June 7, 2002. 22 DCMR 3835.5 provides:

> Each Supported Residence shall maintain at least one (1) staff person at the residence, whenever a resident is present and a 1:8 staff-to-resident ratio during times of peak activity, such as mealtimes.

For purposes of this provision, a Supported Residence is defined as:

> [a] homelike setting where residential care is provided for eight (8) or fewer individuals who require twenty-four hour (24 hr.) staff supervision and assistance.

22 DCMR 3835.1.

By Respondents' own admission, the 2016 Facility, a 24-hour facility providing residential care, had eight residents on June 7, 2002, and, as such, can be construed as a Supported Residence for purposes of 22 DCMR 3835.1. So construed, Respondents were required by law to have at least one staff person at the 2016 Facility at all times. 22 DCMR 3835.5.

I have found that only one staff person was physically present at the 2016 Facility on June 7, 2002 at the time of Ms. Kelly's visit. On its face, this would appear to satisfy the requirements of 22 DCMR 3835.5. In this case, however, the one staff person that was physically present at the 2106 Facility, Ms. Frasier, was designated as the Residence Director for the 2020 Facility, not the 2016 Facility. PX 100. Because the 2016 Facility is separately licensed from the 2020 Facility, each facility must, independently of each other, satisfy the staffing requirements of 22 DCMR 3835.5 in order to be in compliance. *Cf. DOH v. Newcomb Day Care Center*, OAH No. I-00-40411 at 7 (Final Order, January 4, 2002) (noting for purposes of child development facility staffing regulations, a separately-licensed facility, even if physically joined and under common ownership, must independently meet staffing requirements as if it were a "stand alone" facility). In this instance, the 2016 Facility did not independently satisfy the staffing requirements of § 3835.5 because, from a regulatory standpoint, no 2016 Facility staff was present at the time of Ms. Kelly's visit. Respondents are, therefore, liable for violating § 3835.5. A fine of $500 is authorized for a first violation of this regulation, and I will impose that fine. 16 DCMR §§ 3201.1(b)(1) and 3241.2(t).

The failure to properly staff a mental health community residence facility is a serious matter. Those who own and operate such facilities owe the highest obligation not only to their consumers, some of our most vulnerable citizens, but to the public at large to be in full

compliance with the letter and spirit of the laws regulating those facilities. As one court recently observed with respect to the care of the mentally disabled:

> We consider it self-evident that a group home that takes on the supervision, custody and control of a disabled person stands in a "special relationship" to such person for purposes of the person's protection . . . [C]aregivers . . . assume enhanced responsibilities in protective or custodial situations, and this increased duty obligates the caregivers to shield the protected person from the foreseeable consequences of injurious conduct.

Strauss v. Oconomowoc Residential Programs, Inc., 621 N.W.2d 917, 921 (Wis. Ct. App. 2000) (citations omitted).

Respondents have stated that they have disciplined the employees involved in this unfortunate incident. While Respondents' *post hoc* disciplinary efforts are commendable, they are not a substitute for adequate employee oversight and training in the first instance. The consumers of these facilities and the public at large deserve nothing less.

IV. ORDER

Upon the foregoing findings of fact and conclusions of law and the entire record in this matter, it is, therefore, this _____ day of _____, 2002:

ORDERED, that Respondents HFM Enterprises, Inc. and Hilbert H. Humphrey are **LIABLE** for violating 22 DCMR 3835.5 on June 7, 2002 as charged in Notice of Infraction (No. 90007); and it is further

ORDERED, that Respondents, who are jointly and severally liable, shall pay a fine in the total amount of **FIVE HUNDRED DOLLARS ($500)** in accordance with the attached instructions within 20 calendar days of the date of mailing of this Order (15 calendar days plus 5

days for service by mail pursuant to D.C. Official Code §§ 2-1802.04 and 2-1802.05); and it is further

ORDERED, that, if Respondents fail to pay the above amount in full within 20 calendar days of the date of mailing of this Order, by law, interest must accrue on the unpaid amount at the rate of 1½ % per month or portion thereof, beginning with the date of this Order, pursuant to D.C. Official Code § 2-1802.03(i)(1); and it is further

ORDERED, that failure to comply with the attached payment instructions and to remit a payment within the time specified will authorize the imposition of additional sanctions, including the suspension of Respondents' licenses or permits pursuant to D.C. Official Code § 2-1802.03(f), the placement of a lien on real or personal property owned by Respondents pursuant to D.C. Official Code § 2-1802.03(i) and the sealing of Respondents' business premises or work sites pursuant to D.C. Official Code § 2-1801.03(b)(7).

/s/ 10/31/02

Mark D. Poindexter
Administrative Judge